DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 0 1 7

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 9, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 405 IAC 1-12-1, 1-12-2; 1-12-4, 5, 6, 7, 8, 9; 405 IAC 1-12-12, 13, 14, 15, 16, 17, 19, 24, 26

7. FEDERAL BUDGET IMPACT: Cost Savings
a. FFY 03 $ -0-
b. FFY 04 $ 2 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 69, 70, 71, 71A, 72, 72A, 73, 77, 78, 80, 81, 82, 83, 84, 85, 92, 93, 96, 99, 100, 104, 106, 114, 115, 117, 118

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages 69, 70, 71, 71A, 72, 73, 77, 78, 80, 81, 82, 83, 84, 85, 92, 93,96, 99, 100, 104, 106, 114, 115, 117, 118

10. SUBJECT OF AMENDMENT: Large and small private intermediate care facilities for the mentally retarded (ICFs/MR). Rebases provider rates every other year beginning 10-1-02; changes the index for the calculation of the capital return factor to conform with current market factors; makes other minor techncial changes to the rule.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Melanie Bella

13. TYPED NAME:
Melanie Bella

14. TITLE:
Assistant Secretary

15. DATE SUBMITTED:
December 2, 2002

16. RETURN TO:
Melanie Bella, Assistant Secretary
Office of Medicaid Policy and Planning
402 W. Washington St., Room W382
Indianapolis, Indiana 46204
ATTN: Tracy Brunner

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/10/02

18. DATE APPROVED:
1/23/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
11/9/02

20. SIGNATURE OF REGIONAL OFFICIAL:
Bruce Smith

21. TYPED NAME:
CHARLENE BROWN

22. TITLE:
Deputy Director

23. REMARKS:

RECEIVED
DEC 10 2002
DMCH/ARA

FORM HCFA-179 (07-92)

Instructions on Back

Rule 12. Rate-Setting Criteria for Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled

405 IAC 1-12-1 Policy; scope

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified intermediate care facilities for the mentally retarded (ICF/MR), with the exception of those facilities operated by the state, and community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by 405 IAC 1-17. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1)Proper and current certification.

(2)Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish

effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and compensate providers for reasonable, allowable costs. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

(d) The office may implement Medicaid rates and recover overpayments from previous rate reimbursements, either through deductions of future payments or otherwise, without awaiting the outcome of the administrative appeal process.

(e) Providers must pay interest on all overpayments. The interest charge shall not exceed the percentage set out in IC 12-15-13-3(f)(1). The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists.

405 IAC 1-12-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "All-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing or resident care, room and board, supplies, and all ancillary services within a single, comprehensive amount.

(c) "Allowable cost determination" means a computation performed by the office or its contractor to determine the per patient day cost based on a review of an annual financial report and supporting information by applying this rule.

(d) "Allowable per patient or per resident day cost" means a ratio between total allowable costs and patient or resident days.

(e) "Annual or historical financial report" refers to a presentation of financial data, including appropriate supplemental data and accompanying notes derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule which shall constitute a comprehensive basis of accounting.

(f) "Annualized" means restating an amount to an annual value. This computation is performed by multiplying an amount applicable to a period of less or greater than three hundred sixty-five (365) days, by a ratio determined by dividing the number of days in the reporting period by three hundred sixty-five (365) days, except in leap years, in which case the divisor shall be three-hundred sixty-six (366) days.

(g) "Average inflated allowable cost of the median patient day" means the inflated allowable per patient day cost of the median patient day from all providers when ranked in numerical order based on average inflated allowable cost. The average inflated allowable cost shall be computed on a statewide basis for like levels of care, with the exception noted in this subsection, and shall be maintained by the office and revised four (4) times per year effective April 1, July 1, October 1, and January 1. If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the average inflated allowable cost for developmental training homes shall be computed on a statewide basis utilizing all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the average inflated allowable cost for small behavior management residences for children shall be the average inflated allowable cost for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs. If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the average inflated allowable cost of the median patient day for small extensive medical needs residences for adults shall be the average inflated allowable cost of the median patient day for basic developmental increased by one hundred fifty-nine percent (159%).

(h) "Change of provider status" means a bona fide sale, lease, or termination of an existing lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under section 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties.

(i) "Cost center" means a cost category delineated by cost reporting forms prescribed by the office,

(j) "CRF/DD" means a community residential facility for the developmentally disabled.

(k) "DDARS" means the Indiana division, of disability, aging, and rehabilitative services.

(l) "Debt" means the lesser of the original loan balance at the time of acquisition and original balances

of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(m) "Desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor' s written findings and recommendations.

(n) "Equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

(o) "Field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(p) "Forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(q) "General line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(r) "Generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(s) "ICF/MR" means an intermediate care facility for the mentally retarded.

(t) "Like levels of care" means:

(1) care within the same level of licensure provided in a CRF/DD; or

(2) care provided in a nonstate-operated ICF/MR.

(u) "Non-rebasing year" means the year during which non-state operated ICFs/MR and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a non-rebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be non-rebasing years:

October 1, 2003 through September 30, 2004

October 1, 2005 through September 30, 2006

October 1, 2007 through September 30, 2008

October 1, 2009 through September 30, 2010

And every second year thereafter.

(v) "Office" means the Indiana office of Medicaid policy and planning,

(w) "Ordinary patient or resident related costs" means costs of services and supplies that are necessary in delivery of patient or resident care by similar providers within the state.

(x) "Patient or resident/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(y) "Profit add-on" means an additional payment to providers in addition to allowable costs as an incentive for efficient and economical operation.

(z) "Reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction not to exceed the limitations set out in this rule.

(aa) "Rebasing year" means the year during which non-state operated ICFs/MR and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:

October 1, 2002 through September 30, 2003

October 1, 2004 through September 30, 2005

October 1, 2006 through September 30, 2007

October 1, 2008 through September 30, 2009

And every second year thereafter.

(bb) "Related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies.

(cc) "Routine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care.

(dd) "Unit of service" means all patient or resident care at the appropriate level of care included in the established per diem rate required for the care of a patient or resident for one (1) day (twenty-four (24) hours).

(ee) "Use fee" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule.

405 IAC 1-12-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change

(d) Failure to submit an annual financial report within the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received, and the effective date of the Medicaid rate calculated utilizing the delinquent annual financial report shall be the first day of the month after the delinquent annual financial report is received by the office. All limitations in effect at the time of the original effective date of the annual rate review shall apply.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost as a result of this penalty cannot be recovered by the provider.

405 IAC 1-12-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation, a new type of certified service, a new type of licensure for an existing group home, or a change of provider status shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or type of licensure. Initial interim rates will be set at the greater of:

(1) the prior provider's then current rate, including any changes due to a field audit, if applicable; or

(2) the fiftieth percentile rates as computed in this subsection.

Initial interim rates shall be effective upon the later of the certification date, the effective date of a licensure change, or the date that a service is established. The fiftieth percentile rates shall be computed on a statewide basis for like levels of care, except as provided in subsection (b), using current rates of all CRF/DD and ICF/MR providers. The fiftieth percentile rates shall be maintained by the office, and a revision shall be made to these rates four (4) times per year effective on April 1, July 1, October 1, and January 1.

(b) If there are fewer than six (6) homes with rates established that are licensed as developmental training homes, the fiftieth percentile rates for developmental training homes shall be computed on a statewide basis using current rates of all basic developmental homes with eight and one-half (8 1/2) or fewer hours per patient day of actual staffing. If there are fewer than six (6) homes with rates established that are licensed as small behavior management residences for children, the fiftieth percentile rate for small behavior management residences for children shall be the fiftieth percentile rate for child rearing residences with specialized programs increased by two hundred forty percent (240%) of the average staffing cost per hour for child rearing residences with specialized programs. If there are fewer than six (6) homes with rates established that are licensed as small extensive medical needs residences for adults, the fiftieth percentile rate for small extensive medical needs residences for adults shall be the fiftieth percentile rate for basic developmental increased by one hundred fifty-nine percent (159%).

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation and an extension has not been granted, the initial interim

rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider. The effective date of the base rate calculated utilizing the delinquent historical financial report shall be the first day of the month after the delinquent historical financial report is received by the office. All limitations in effect at the time of the original effective date of the base rate review shall apply.

(g) Except as provided in section 17(f) of this rule, neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as established in this rule.

405 IAC 1-12-6 Active providers; rate review; annual request

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 6.(a) The rate effective date of the annual rate review established during the rebasing years and non-rebasing years shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period.

(b) The annual rate review that shall become effective during a rebasing year shall be established using the annual financial report as the basis of the review.

(c) The annual rate review that shall become effective during a non-rebasing year shall be established by applying an inflation adjustment to the previous year's annual or base Medicaid rate. The inflation adjustment prescribed by this subsection shall be applied by using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the previous year's annual or base Medicaid rate period to the midpoint of the current year annual Medicaid rate period prescribed as follows:

Rate Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

405 IAC 1-12-7 Request for rate review; effect of inflation; occupancy level assumptions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 7. (a) Rate setting during rebasing years shall be based on the provider's annual or historical financial

report for the most recent completed year. In determining prospective allowable costs during rebasing years, each provider's costs from the most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint of the expected rate period.

(b) For purposes of determining the average allowable cost of the median patient day as applicable during rebasing years, each provider's costs from their most recent completed year will be adjusted for inflation by the office using the following methodology. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual or historical financial report period to the midpoint prescribed as follows:

Median Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year I	January 1, Year 2
October 1, Year 1	April 1, Year 2

(c) For ICFs/MR and CRFs/DD, allowable costs per patient or resident day shall be determined based on an occupancy level equal to the greater of actual occupancy, or ninety-five percent (95%) for ICFs/MR and ninety percent (90%) for CRFs/DD, for certain fixed facility costs. The fixed costs subject to this minimum occupancy level standard include the following:

(1)Director of nursing wages.

(2)Administrator wages.

(3)All costs reported in the ownership cost center, except repairs and maintenance.

(4)The capital return factor determined in accordance with sections twelve (12) through seventeen (17) of this rule.

405 IAC 1-12-8 Limitations or qualifications to Medicaidreimbursement; advertising; vehicle basis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2